IRO Express Inc.

An Independent Review Organization

Phone Number:	**2131 N Collins PMB 433409**	***Fax Number:***
(682) 238-4976	**Arlington, TX 76011**	**(817) 385-9611**
	Email:iroexpress@irosolutions.com	

Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Physical Therapy 2 X wk X 3 wks right sacral region

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a female whose date of injury is xx/xx/xx. On this date she was at work when she slipped and landed directly on her anterior kneecap on the left side. Note dated 05/19/14 indicates that she has been attending physical therapy once a week and feels that her range of motion has improved. The patient underwent left knee diagnostic arthroscopy with manipulation under anesthesia and partial medial meniscectomy on 06/03/14. Note dated 07/02/14 indicates that the patient reports no pain in her knee. She reports that home exercises are done daily. Note dated 09/24/14 indicates that the patient reports she is doing well but still has occasional 1-1.5/10 pain. She is no longer attending physical therapy. Follow up note dated 12/15/14 indicates that the patient presents with some low back pain and SI joint pain, and she was recommended for additional physical therapy. On physical examination range of motion, strength and tone are normal in the right lower extremity. Left knee demonstrates 0-130 degrees of flexion. She has a negative McMurray's. Note dated 12/22/14 indicates that current medications are ibuprofen, Norco, Tylenol and Ultram.

Initial request for physical therapy 2 x wk x 3 wks right sacral region was non-certified on 12/30/14 noting that the clinical information submitted for review indicates the patient previously participated in physical therapy. There is a lack of documentation related to the previous number of physical therapy visits and the most recent date. There is a lack of documentation related to the functional therapeutic benefit of the previous physical therapy. The denial was upheld on appeal dated 01/16/15 noting that the note dated 12/15/14 did not provide a physical assessment of the lumbar spine to include any range of motion deficits. The physical therapy notes dated 12/22/14 state the patient had received physical therapy related to the lower back. There is lack of documentation that indicates the amount of physical therapy the patient has received to date.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient sustained injuries on xx/xx/xx to the back and left knee and has undergone extensive prior physical therapy. The number of physical therapy visits directed at the back is not documented. The submitted records indicate that the patient is compliant with a home exercise program. There is no current, detailed physical examination submitted for review of the patient's low back. There is no clear rationale provided as to why additional supervised physical therapy is necessary versus an active home exercise program. Therefore, medical necessity of the request for physical therapy x 6 visits is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for physical therapy 2 x wk x 3 wks right sacral region is not recommended as medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)